STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155501		08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 25, 26, 27, 28, 29, and August 1, 2016 Facility number: 000465 Provider number: 155501 AIM number: 100273870 Census bed type: SNF/NF: 42 Total: 42 Census payor type: Medicare: 3 Medicaid: 31 Other: 8 Total: 42 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 11474 on August 3, 2016.	F 0000	The facility requests that the plan of correction be considered its credible allegation of compliance Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies The plan of correction is prepared and/or executed solely because of federal and state law The facility also respectfully requests a desk review of this plan of correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a Restorative Nursing Program for 1 of 3 residents (Resident #13) who met the criteria for contracture without ROM (range of motion) or splint device. Findings include:	F 0279	F 279 – D: Develop Comprehensive CarePlans It is the intent of the facility to use the results of assessments to develop, review and revise the resident's comprehensive plan of care to maintain the resident's highest level of medical,nursing, mental, and psychosocial needs. The facility failed to develop a comprehensive care	08/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the clinical record for Resident #13, on 7/26/16 at 2:08 p.m., indicated the following: diagnoses included, but were not limited to, pressure ulcer, muscle weakness, multiple sclerosis, paraplegia, diabetes mellitus, colorectal mass, peripheral vascular disease, contracture of right knee, contracture of right elbow, contracture of left knee, and contracture of muscle, multiple sites. A Minimum Data Set (MDS) assessment for Resident #13, dated 5/17/16, indicated impairments on both upper and lower extremities. A Health Status Note for Resident #13, dated 2/6/16, indicated she had returned to the facility from a stay in the hospital for surgery, with a resultant fractured right humerus (upper arm). A physician's order for Resident #13, dated 2/8/16, indicated for Occupational Therapy (OT) to evaluate and treat for skilled OT 5 x (times) week x 8 weeks of therapeutic exercises, neuromuscular re-education, and massage to manage contractures on the right elbow and edema in the right upper extremity. An Occupational Therapy Evaluation and Plan of Treatment for Resident #13,		plan for one resident who met the criteria for contracture with range of motion or splintdevice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #13 care plans to be reviewed for accuracy and updated as needed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected that have been discharged from therapy services. The Therapy Manager will identify all residents within the facility that have been discharged from therapy services to restorative nursing services over the past twelve months. The RestorativeNurse Manager will develop a restorative nursing plan for those residents based off therapy recommendations. The clinical team will review the resident care plans for accuracy and update as needed. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur:** Systematic changes will include: ·Prior to theresident discharging from therapy services, the therapists are to develop a restorative nursing program or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 2/8/16, indicated she was referred for therapy due to a right elbow contracture following a right humeral fracture. The evaluation also indicated she had muscle weakness. The evaluation further indicated she was at greater risk for further contractures and required skilled OT services to manage contractures in the right elbow area. The goals established were for Resident #13 to increase PROM (passive range of motion) to her right elbow and exhibit a decrease in edema in the right upper extremity. An Occupational Therapy Progress Report for Resident #13, dated 2/12/16, indicated her right elbow was in a contracted flexed position and she would not be able to tolerate her right elbow extension brace. The report also indicated skilled OT services were warranted to develop and instruct on compensatory strategies in order to enhance patient's quality of life by improving ability to be able to return to prior level of living. An Occupational Therapy Discharge Summary for Resident #13, dated 2/19/16, indicated she had no significant progress with her right elbow range of motion. The summary also indicated the development and instruction in a		functional maintenance program, if it is deemed necessary ·Each therapist is to coordinate with the Restorative Nurse Manager to ensure continuation of care for that resident ·Each therapist is to give a copy of the program to the Rehab Services Manager and to the Restorative Nurse Manager prior to discharging the resident from services ·The RestorativeNurse Manager will care plan the restorative nursing program or functional maintenance program within 72 hours of implementation of that program **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur:** Monitoring of this systematic change will be completed utilizing the “RNP/FMP Care Plan Log” by the Restorative Nurse Manager. This log will be completed daily as residents discharge from therapy. The log will be reviewed in the QAPI meeting monthly x 3 and quarterly x 3 or until the team is confident that continued compliance is achieved. (See Attached form)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restorative nursing program/functional maintenance program, passive range of motion, had been completed to maintain her current level of performance and in order to prevent decline. A physician's order for Resident #13, dated 2/8/16, indicated Physical Therapy (PT) to evaluate and treat 5 x week for 8 weeks for therapeutic exercises, therapeutic activities, neuro-muscular re-education, E-Stim, and modality application, diathermy, supervised. A Physical Therapy Evaluation and Plan of Treatment for Resident #13, dated 2/8/16, indicated she was referred due to exhibiting a new onset of decrease in strength, paralysis/paresis, decrease in range of motion and joint stability placing her at risk for further decline in function, and contractures. The evaluation also indicated she had a fracture of her right humerus, a contracture to her right elbow, and a contracture to her right knee. The evaluation further indicated skilled PT for right knee and ankle contracture management and orthotic management. A Physical Therapy Progress Report for Resident #13, dated 2/8/16, indicated she was progressing with current treatment interventions. The report also indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she required skilled physical therapy services to increase lower extremity range of motion and strength, and enhance rehab potential. The progress note further indicated a RNP would be developed and instruction provided in order to enhance patient's quality of life by improving ability to safely maneuver in/out of bed. A Physical Therapy Discharge Summary for Resident #13, dated 2/19/16, indicated she was treated for bilateral lower extremity knee and ankle range of motion with passive stretching and positioning. The summary also indicated the development and instruction in a restorative nursing program, passive range of motion, had been completed with the interdisciplinary team to facilitate the resident in maintaining her current level of performance and in order to prevent decline. A physician's order for Resident #13, dated 2/19/16, indicated to discontinue from skilled PT and skilled OT services. Therapist #1 was interviewed on 7/28/16 at 9:50 a.m. During the interview, she indicated therapy had worked with Resident #13 off and on over the years with splinting. She also indicated therapy had backed off working with her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	after her arm was broken during a hospital stay. She further indicated a Restorative Program had not been written for her and therapy had to wait for nursing to initiate a referral in order for therapy to see her again. The MDS (Minimum Data Set) Coordinator was interviewed on 7/28/16 at 3:45 p.m. During the interview, she indicated Resident #13 was not on a restorative nursing program for passive range of motion. Therapist #1 was interviewed on 7/28/16 at 4:00 p.m. During the interview, she indicated she did not realize OT and PT had recommended Restorative Nursing Programs for Resident #13. The Director of Nursing was interviewed on 7/28/16 at 4:06 p.m. During the interview she indicated if therapy recommended a restorative nursing program, it should be implemented. A current facility policy "Introduction to Restorative Nursing Process" for Resident #13, dated July 2010 and provided by the MDS Coordinator on 8/1/16 at 9:05 a.m., indicated "Restorative Nursing is a collection of interventions designed to promote independence and safety...The goal, at all			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	levels, is to restore the resident's functionality whenever possible, improve the ability for self-care, and maintain independence as long as possible." 3.1-35(a)			
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on interview and record review, the facility failed to provide passive range of motion for 1 of 3 residents (Resident #13) who met the criteria for contracture without ROM (range of motion) or splint device. Findings include: Review of the clinical record for Resident #13 on 7/26/16 at 2:08 p.m., indicated the following: diagnoses included, but were not limited to, pressure ulcer, muscle weakness, multiple sclerosis, paraplegia, diabetes mellitus, colorectal mass, peripheral vascular disease, contracture of right knee, contracture of right elbow, contracture of left knee, and contracture	F 0318	F318 – D: Increase / Prevent Decrease in Range of Motion It is the intent of the facility to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. The facility failed to provide a passive range of motion program for one resident who met the criteria for contracture without range of motion or splint device. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident #13 is being picked up on occupational therapy's caseload with a subsequent restorative nursing program being developed.	08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of muscle, multiple sites. A Minimum Data Set (MDS) assessment for Resident #13, dated 5/17/16, indicated impairments on both upper and lower extremities. A Health Status Note for Resident #13, dated 2/6/16, indicated she had returned to the facility from a stay in the hospital for surgery, with a resultant fractured right humerus (upper arm). A physician's order for Resident #13, dated 2/8/16, indicated for Occupational Therapy (OT) to evaluate and treat for skilled OT 5 x (times) week x 8 weeks of therapeutic exercises, neuromuscular re-education, and massage to manage contractures on the right elbow and edema in the right upper extremity. An Occupational Therapy Evaluation and Plan of Treatment for Resident #13, dated 2/8/16, indicated she was referred for therapy due to a right elbow contracture following a right humeral fracture. The evaluation also indicated she had muscle weakness. The evaluation further indicated she was at greater risk for further contractures and required skilled OT services to manage contractures in the right elbow area. The goals established were for Resident #13		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected that have been discharged from therapy services or have contractures. The Therapy Manager will identify all residents within the facility that have been discharged from therapy services to restorative nursing services over the past twelve months. The Restorative Nurse Manager will develop a restorative nursing plan for those residents based off therapy recommendations. The Restorative Nurse Manager will identify all residents in house that have a diagnosis of a contracture and review them for appropriate restorative nursing programs. The clinical team will review the resident care plans for accuracy and update as needed. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur:** Systematic changes will include: ·Education will be provided to the members of the clinical team by the Rehab Services Manager regarding the referral to therapy process ·Education will be provided to the members of the therapy team by the Rehab Services Manager regarding the referral process for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to increase PROM (passive range of motion) to her right elbow and exhibit a decrease in edema in the right upper extremity. An Occupational Therapy Progress Report for Resident #13, dated 2/12/16, indicated her right elbow was in a contracted flexed position and she would not be able to tolerate her right elbow extension brace. The report also indicated skilled OT services were warranted to develop and instruct on compensatory strategies in order to enhance patient's quality of life by improving ability to be able to return to prior level of living. An Occupational Therapy Discharge Summary for Resident #13, dated 2/19/16, indicated she had no significant progress with her right elbow range of motion. The summary also indicated the development and instruction in a restorative nursing program/functional maintenance program, passive range of motion, had been completed to maintain her current level of performance and in order to prevent decline. A physician's order for Resident #13, dated 2/8/16, indicated Physical Therapy (PT) to evaluate and treat 5 x week for 8 weeks for therapeutic exercises,		restorative nursing and functional maintenance programs ·Prior to the resident discharging from therapy services, the therapists are to develop a restorative nursing program or functional maintenance program, if it is deemed necessary ·Each therapist is to coordinate with the Restorative Nurse Manager to ensure continuation of care for that resident ·Each therapist is to give a copy of the program to the Rehab Services Manager and the Restorative Nurse Manager prior to discharging the resident from services ·Prior to discharging the resident from therapy services, the therapist is to inservice nursing staff on each program **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur:** Monitoring of this systematic change will be done utilizing the “Therapy Restorative Tracker” for all therapy discharges by the Rehab Services Manager. Monitoring of this systematic change will be done utilizing the “RNP/FMP Contracture Log” by the Restorative Nursing Manager. These logs will be reviewed in the QAPI meeting monthly x 3 and quarterly x 3 or until the team is confident that continued compliance is achieved. (See	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	therapeutic activities, neuro-muscular re-education, E-Stim, and modality application, diathermy, supervised. A Physical Therapy Evaluation and Plan of Treatment for Resident #13, dated 2/8/16, indicated she was referred due to exhibiting a new onset of decrease in strength, paralysis/paresis, decrease in range of motion and joint stability placing her at risk for further decline in function, and contractures. The evaluation also indicated she had a fracture of her right humerus, a contracture to her right elbow, and a contracture to her right knee. The evaluation further indicated skilled PT for right knee and ankle contracture management and orthotic management. A Physical Therapy Progress Report for Resident #13, dated 2/8/16, indicated she was progressing with current treatment interventions. The report also indicated she required skilled physical therapy services to increase lower extremity range of motion and strength, and enhance rehab potential. The progress note further indicated a RNP would be developed and instruction provided in order to enhance patient's quality of life by improving ability to safely maneuver in/out of bed.		attached forms)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physical Therapy Discharge Summary for Resident #13, dated 2/19/16, indicated she was treated for bilateral lower extremity knee and ankle range of motion with passive stretching and positioning. The summary also indicated the development and instruction in a restorative nursing program, passive range of motion, had been completed with the interdisciplinary team to facilitate the resident in maintaining her current level of performance and in order to prevent decline. A physician's order for Resident #13, dated 2/19/16, indicated to discontinue from skilled PT and skilled OT services. Therapist #1 was interviewed on 7/28/16 at 9:50 a.m. During the interview, she indicated therapy had worked with Resident #13 off and on over the years with splinting. She also indicated therapy had backed off working with her after her arm was broken during a hospital stay. She further indicated a Restorative Program had not been written for her and therapy had to wait for nursing to initiate a referral in order for therapy to see her again. The MDS (Minimum Data Set) Coordinator was interviewed on 7/28/16 at 3:45 p.m. During the interview, she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident #13 was not on a restorative nursing program for passive range of motion. Therapist #1 was interviewed on 7/28/16 at 4:00 p.m. During the interview she indicated she did not realize OT and PT had recommended Restorative Nursing Programs for Resident #13. The Director of Nursing was interviewed on 7/28/16 at 4:06 p.m. During the interview, she indicated if therapy recommended a restorative nursing program, it should be implemented. The Director of Nursing was interviewed on 7/29/16 at 9:48 a.m. During the interview she indicated nursing staff were notified by therapy on a telephone order slip when a restorative program was being initiated. The order would state "Refer to Restorative." She also indicated therapy was to provide nursing with a written restorative program for each resident that was to receive restorative services. A current facility policy "Introduction to Restorative Nursing Process" for Resident #13, dated July 2010 and provided by the MDS Coordinator on 8/1/16 at 9:05 a.m., indicated "Restorative Nursing is a collection of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155501		08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interventions designed to promote independence and safety...The goal, at all levels, is to restore the resident's functionality whenever possible, improve the ability for self-care, and maintain independence as long as possible. 3.1-42(a)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure staff washed their hands after touching soiled items and before assisting residents to eat and feeding residents their meals. The facility further failed to ensure beverages on room trays were covered when transported through common hallways. This deficient practice had the potential to affect 42 of 42 residents who received food and beverages prepared and served by the facility. Findings include:	F 0371	F 371 – F: Food Procure, Store / Prepare/ Serve – Sanitary It is the intent of the facility to procure food from sources approved or considered satisfactory by Federal, Stateor local authorities; and store, prepare, distribute and serve food under sanitary conditions. The facility failed to ensure that staff washed their hands after touching soiled items and before assisting residents to eat and feeding residents their meals. The facility failed to ensure that beverages on room trays were covered when transported through common hallways. **What corrective action(s) will be accomplished for those residents found to have been**	08/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. During an observation of the lunch meal on the South Hall on 7/25/16, the following was observed: At 11:21 a.m., the food cart was parked in the middle of the South Hall. Certified Nursing Assistant (CNA) #2 was observed to prepare a cup of hot chocolate at the food cart and place the cup on a meal tray. She was observed to carry the meal tray from the food cart through the South Hall to a resident's room, not in close proximity to the food cart. The cup of hot chocolate was not covered. At 11:24 a.m., CNA #2 was observed to prepare a cup of hot tea at the food cart and place the cup on a meal tray. She was observed to carry the meal tray from the food cart through the South Hall to a resident's room, not in close proximity to the food cart. The cup of hot tea was not covered. At 11:28 a.m., CNA #2 was observed to prepare a cup of hot tea at the food cart and place the cup on a meal tray. She was observed to carry the meal tray from the food cart through the South Hall to a resident's room, not in close proximity to the food cart. The cup of hot tea was not covered.		**affected by the deficient practice:** All appropriate staff to receive education on infection control, hand hygiene, and covering food and drinks on hallway meal trays. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents that participate in dining room or hallway meal service have the potential to be affected. Therefore, the following systematic changes have been put into place. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not reoccur:** Systematic changes will include: ·Education will be provided to nursing staff and any other staff that pass meal trays on infection control related to hand hygiene after touching soiled items ·Education will be provided to nursing staff and any other staff that pass hallway trays on infection control related to covering food and drink items on meal trays ·Education will be provided to dietary staff on providing clear plastic wrap to hall carts for use during meal pass ·Education will be provided during orientation and then annually on infection control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At 11:31 a.m., CNA #2 prepared a hot beverage at the food cart and place the cup on a meal tray. She was observed to cover the hot beverage with the resident's paper meal slip and carry the meal tray from the food cart from the South Hall, passing by the nursing station and the main entrance of the facility, to the Reflections Hall. The hot beverage was not covered appropriately to protect it from potential contamination. 2. During an observation of the lunch meal in the dining room on 7/25/16, the following was observed: At 11:38 a.m., RN #3 was observed to pull a dining room chair up next to a resident seated at a dining room table using her hands. She was observed to pick up the resident's spoon to assist her to eat. She was not observed to re-wash her hands after touching a soiled item. At 11:41 a.m., an unidentified staff carried a dining room chair over next to a resident seated at a dining room table. A second staff, RN #4, was observed to sit down on the chair and move it closer to the resident using her hands. She then picked up the resident's eating utensil and started to feed the resident her lunch meal. She was not observed to re-wash her hands after touching a soiled item.		related to hand hygiene after touching soiled items and covering food items during hallway meal pass ·Rolling stools to be ordered for staff to use while assisting residents in the dining room **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur:** Monitoring of this systematic change will be done utilizing the "Dining Room Infection Control Log" and "Hall Tray Infection Control Log" and "Handwashing Log" by the Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator. These audits will be completed for five meals weekly x12 weeks, then monthly x3 months, and quarterly x2 months. These logs will be reviewed in the QAPI meeting monthly x 3 and quarterly x 3 or until the team is confident that continued compliance is achieved. (See attached forms)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At 11:42 a.m., CNA #5 was observed to move a dining room chair over next to a resident seated at a dining room table using her hands. She then sat down on the chair and began feeding the resident his lunch meal. She was not observed to re-wash her hands after touching a soiled item. At 11:46 a.m., LPN #6 was observed to move a chair on wheels over to a resident seated at a dining room table using her hands. She then sat down on the chair and picked up the resident's eating utensils to cut her food. She then fed the resident her lunch meal. She was not observed to re-wash her hands after touching a soiled item. 3. During an observation of the lunch meal on the South Hall on 7/26/16, the following was observed: At 11:27 a.m., the food cart was parked in the middle of the South Hall. CNA #2 was observed to prepare a glass of ice tea at the food car and place the glass on a meal tray. She was observed to carry the meal tray from the South Hall to the Reflections Hall, passing by the nursing station and the main entrance of the facility. The glass of ice tea was not covered.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. During an observation of the lunch meal on the Reflections Hall On 7/27/16 , the following was observed: At 11:26 a.m., the food cart was parked in the middle of the Reflections Hall. An unidentified CNA was observed to carry a meal tray from the Reflections Hall to the South Hall, passing by the nursing station and the main entrance into the facility. The meal tray contained a cup of coffee which was not covered. 5. During an observation of the lunch meal in the dining room on 7/27/16, the following was observed: At 11:39 a.m., CNA #5 was observed to use hand sanitizer on her hands and moved a stool on wheels over next to a resident seated at a dining room table with her feet. She was observed to hike up her slacks with her hands while sitting on the stool. She then began to feed the resident her lunch meal. She was not observed to re-wash her hands after touching her uniform. She then was observed to get up and leave the table. At 11:41 a.m., RN #3 was observed to approach the same resident, touching the resident's wheelchair with her hands. She was observed to sit down on the stool			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with wheels and start to feed the resident her lunch meal. She was not observed to re-wash her hands after touching a soiled item. At 11:44 a.m., RN #3 was observed to don a pair of disposable gloves to assist the resident to eat a slice of cheese. She was not observed to re-wash her hands prior to donning the disposable gloves. At 11:45 a.m., CNA #5 was observed to use hand sanitizer on her hands. She was observed to hike up her slacks with her hands while sitting in a dining room chair in-between two residents. She handed the resident on her left a glass of nutritional supplement which the resident took into her hands to drink. CNA #5 then began to feed the resident on her right side without re-washing her hands. At 11:51 a.m., CNA #5 was reminded to wash her hands by the Director of Nursing. CNA #5 returned to the dining room table after washing her hands and then touched her clean hands to her uniform top. She then resumed feeding the resident on her right side without re-washing her hands. At 12:00 p.m., LPN #7 was observed to enter the dining room and sit down next to a resident to assist her with her lunch			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	meal. She was only observed to wash her hands after being reminded by the Director of Nursing. At 12:03 p.m., RN #8 was observed to enter the dining room and wash her hands. She was then observed to move a stool on wheels over to a table next to a resident using her fingertips. She then began to feed the resident the lunch meal. She was not observed to re-wash her hands. 6. During an observation of the lunch meal on South Hall on 7/28/16, the following was observed: At 11:25 a.m., the food cart was parked in the middle of the South Hall. CNA #2 was observed to prepare 2 cups of coffee at the food cart and place them on meal trays. She was observed to carry the meal trays through the South Hall to resident rooms. The mugs of coffee were not covered. At 11:41 a.m., CNA #2 was observed to prepare a glass of ice tea at the food cart and place the glass on a meal tray. She was observed to carry the meal tray from the South Hall to the Reflections Hall, passing by the nursing station and the main entrance of the facility. The glass of ice tea was not covered.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF BLUFFTON	1529 W LANCASTER ST BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Certified Dietary Manager (CDM) was interviewed on 8/1/16 at 9:09 a.m. During the interview she indicated staff were to wash their hands after touching soiled objects and feeding residents. She also indicated the food cart was to be moved from room to room when hall trays were delivered. She further indicated all food and beverages were to be protected from contamination. A current facility policy "Nursing Department Responsibilities at Mealtime", revised on 9/1/14 and provided by the CDM on 8/1/16 at 9:38 a.m., indicated "...Nursing cannot touch ready-to-eat food with their hands and should wash their hands between touching a resident, themselves, soiled items and clean items in order to prevent cross contamination...." A current facility policy "Trayline Setup and Service", revised on 3/14/16 and provided by the CDM on 8/1/16 at 10:48 a.m., indicated "...If tray is going to the floor all items must be covered on the tray unless the tray is transported in an enclosed cart and the tray is taken directly to the resident from the enclosed cart...." 3.1-21(i)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/01/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE